

APPENDIX A

MISSOURI COURT OF APPEALS
WESTERN DISTRICT

MISSOURI DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,
Respondent,
vs.
NME HOSPITAL, INC.
d/b/a Lutheran Medical Center, et al.,
Appellants.

WD56901(Consolidated with WD56902 through
WD56911 and WD57007)

Opinion Filed: December 28, 1999

APPEAL FROM THE CIRCUIT COURT
OF COLE COUNTY
The Honorable Thomas Joseph Brown III, Judge

Before Spinden, P.J., Lowenstein, J. and Ulrich, J.

NME Hospital, Inc. d/b/a Lutheran Medical Center and eleven other hospitals[1] (Hospitals) appeal the judg-

[1]Deaconess Health Services Corporation d/b/a Deaconess Hospital; St. John's Regional Health Center; St. Louis University d/b/a St. Louis University Medical Center; Southeast Missouri Hospital Association d/b/a Southeast Missouri Hospital; Lucy Lee Hospital; St. Luke's Northland Hospital; Deaconess Medical Center-West Campus; Psychiatric Healthcare Corporation of Missouri d/b/a Lakeland Regional Hospital; St. John's Regional Medical Center; BHCA of Kansas City, Inc. d/b/a ValueMark Behavioral Healthcare of Kansas City d/b/a North Hills Hospital; Missouri Healthcare System, L.P.

ment of the circuit court reversing the order of the Administrative Hearing Commission (AHC) finding that Hospitals were entitled to Medicaid reimbursements of over $30,000,000 after the invalidation of a cap imposed by the Department of Social Services, Division of Medical Services (DMS) on reimbursement rates for certain inpatient psychiatric services. In reversing the AHC's order, the circuit court found that the AHC lacked subject matter jurisdiction to hear Hospitals' complaints. The judgment of the circuit court is affirmed.

DMS is the state agency responsible for administering the Medicaid program in the State of Missouri. Hospitals owned and operated duly licensed and accredited hospitals that provided inpatient psychiatric services for which reimbursement was provided under Missouri's Medicaid plan. Prior to January 1, 1990, health care providers within the Missouri Medicaid program received reimbursements from DMS for such services based on a per diem rate. In 1990, DMS adopted a regulation, 13 CSR 70-15.010(15), which placed a ceiling or cap on the per diem reimbursement rates for certain inpatient psychiatric services.

In 1992 and 1993, three hospitals, in three separate cases, challenged the validity of the psychiatric reimbursement cap. This court, in ***Missouri Dep't of Soc. Servs., Div. of Medical Servs. v. Great Plains Hosp., Inc.*, 930 S.W.2d 429, 437 (Mo. App. W.D. 1996)**, found that the cap was invalid based on DMS's failure to meet the procedural requirements of the Boren Amendment[2]

[2]The Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A)(1992), requires a state to establish a scheme for reimbursing health care providers for the medical services they provide to Medicaid patients. ***Great Plains*, 930 S.W.2d at 431 (citing *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 499-502 (1990)).**

in placing the cap on per diem psychiatric reimbursements. The court then found that the hospital was entitled to be reimbursed pursuant to the last validly enacted Medicaid payment plan.[3] ***Id.* at 438**. Based on the holding in ***Great Plains***, DMS withdrew the invalid regulation on October 1, 1996.

Beginning on October 29, 1996, Hospitals filed claims with DMS demanding payment for the difference between the amounts Hospitals would have received without the cap and the amount they actually received for inpatient psychiatric services provided from 1990 through 1995, plus interest. These claims were denied by DMS. Hospitals also filed their complaints in the instant action before the AHC beginning on October 29, 1996, asserting entitlement to additional reimbursements from DMS based on the ***Great Plains*** decision. Thereafter, Hospitals filed motions for summary determination claiming that no factual, only legal, disputes existed. DMS filed its cross motions for summary determination agreeing that the cases involved only legal issues and arguing that Hospitals were not entitled to additional reimbursements under ***Great Plains*** because the AHC lacked subject matter jurisdiction to hear the complaints and Hospitals' complaints were barred by the doctrine of sovereign immunity and the statute of limitations.

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[3]The two companion cases, ***Missouri Dep't of Soc. Servs., Div. of Medical Servs. v. Trinity Lutheran Hosp.*, 930 S.W.2d 426, 429 (Mo. App. W.D. 1996)**, and ***Missouri Dep't of Soc. Servs., Div. of Medical Servs. v. Alexian Bros. of St. Louis, Inc.*, 930 S.W.2d 439, 441 (Mo. App. W.D. 1996)**, were decided the same day as ***Great Plains*** and also held that the hospitals were entitled to be reimbursed at the standard per diem rate based on the invalid cap.

The AHC issued decisions in favor of Hospitals on May 12, 1998, and thereafter. Although the AHC found that it did not have subject matter jurisdiction over Hospitals' claims under section 208.156.2[4], it found that jurisdiction was conferred under section 208.156.4. The AHC also found that DMS waived its sovereign immunity and that no statute of limitations applied to limit recovery. It concluded that under the decision in ***Great Plains*** and the two companion cases, Hospitals were entitled to reimbursements of over $30,000,000 withheld by imposition of the invalid cap from 1990 through 1995.

DMS filed its petitions for judicial review on June 4, 1998, in the circuit court. Hospitals filed cross petitions for judicial review alleging that the AHC failed to grant interest on the liquidated amount for the 13 month period during which Hospitals' motions for summary determination were under consideration. The cases were consolidated, and the circuit court reversed the AHC decisions finding that the AHC lacked subject matter jurisdiction to hear Hospitals' complaints. This appeal followed.

In an administrative review case, an appellate court will review the decision of the AHC and not the judgment of the circuit court. ***Psychcare Management, Inc. v. Department of Soc. Servs., Div. of Medical Servs.*, 980 S.W.2d 311, 312 (Mo. banc 1998)**. An appellate court is generally limited to determining whether the AHC's decision is supported by substantial and competent evidence upon the whole record; whether

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[4]All statutory references are to RSMo 1994 unless otherwise indicated.

the decision is arbitrary, capricious, or unreasonable; or whether the AHC abused its discretion. ***Id.*** The court may not determine the weight of the evidence or substitute its discretion for that of the administrative body. ***Id.*** Questions of law, however, are matters for the independent judgment of the court. ***Id.***

The issue of the AHC's subject matter jurisdiction in this case is dispositive, and the other issues raised are not addressed. Hospitals claim that the AHC had subject matter jurisdiction to hear and decide the complaints based on sections 208.156.2 and 208.156.4. The AHC is a creature of statute and "has only such jurisdiction or authority as may be granted by the legislature." ***Livingston Manor, Inc. v. Department of Soc. Servs., Div. of Family Servs.*, 809 S.W.2d 153, 156 (Mo. App. W.D. 1991)**. If the AHC lacks statutory power to consider a matter, it is without subject matter jurisdiction. ***Id.*** The AHC's jurisdiction in Medicaid service provider cases is conferred by section 621.055, which provides in pertinent part:

> Any person authorized under section 208.153, RSMo, to provide services for which benefit payments are authorized under section 208.152, RSMo, may seek review by the administrative hearing commission of any of the actions of the department of social services specified in subsection 2, 3, or 4 of section 208.156, RSMo.

§ 621.055.1. Thus, if DMS's actions in this case fell within the purview of subsections 2, 3, or 4 of section 208.156, the AHC had jurisdiction to entertain Hospitals' complaints. ***State ex rel. Oakwood Manor Nursing Ctr. v. Stangler*, 809 S.W.2d 90, 92 (Mo. App.**

W.D. 1991). Section 208.156 provides, in pertinent part:

> 2. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 whose claim for reimbursement for such services is denied or is not acted upon with reasonable promptness shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.
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> 3. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is denied participation in any program or programs established under the provisions of chapter 208 shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.
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> 4. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is aggrieved by any rule or regulation promulgated by the department of social services or any division therein shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

§208.156.

The AHC did not have subject matter to hear and decide Hospitals' complaints in this case. First, jurisdiction was not conferred to the AHC pursuant to section 208.156.4. In their complaints, Hospitals, unlike the hospitals in ***Great Plains*** and the two companion

cases, did not challenge the validity of the Medicaid reimbursement cap on psychiatric services. The regulation imposing the cap had been withdrawn by DMS based on ***Great Plains*** prior to the filing of the complaints in this case. Instead, Hospitals sought additional reimbursements over the reimbursements they actually received in prior rate periods, and DMS denied their requests. An agency rule is a statement of policy or interpretation of law of future effect that acts on unnamed and unspecified persons or facts. ***Missouri Health Care Ass'n v. Missouri Dep't of Soc. Servs.*, 851 S.W.2d 567, 569 (Mo. App. W.D. 1993)**. Conversely, an agency decision engages the agency expertise on specific facts. ***Id.*** In this case, Hospitals sought review of DMS decisions—the denials of their claims for additional reimbursements—not of the validity of the psychiatric reimbursement cap as a matter of future policy without reference to named persons or facts. Section 208.156.4, which authorizes a hearing before the AHC for any person aggrieved by a rule or regulation of the Department of Social Services, therefore, did not apply.

Hospitals argue, however, that they are aggrieved by the enforcement of the former regulation for many years, and, thus, are entitled to a hearing before the AHC under section 208.156.4. They contend that the clause "who is aggrieved by any rule or regulation" within section 208.156.4 contemplates both current and past injury. In construing statutes, a court must endeavor to ascertain the intent of the legislature from the language used and give effect to that intent if possible. ***Great Plains*, 930 S.W.2d at 438**. "Legislative intent should be determined by considering the plain and

ordinary meaning of the terms in the statute." ***Id.*** Statutory construction is a question of law. ***Id.*** The plain and ordinary meaning of the clause in section 208.156.4 only encompasses present injury by a rule or regulation. If the General Assembly intended to confer jurisdiction to the AHC over cases where a person was injured or harmed in the past by a prior regulation and may continue to be injured into the present, it would have explicitly done so. Section 208.156.4, therefore, only gives the AHC jurisdiction in cases where a person is presently injured by an existing rule. At the time Hospitals filed their complaints with the AHC, the regulation that Hospitals claim injured them was no longer in existence. Section 208.156.4, therefore, did not confer jurisdiction to the AHC in this case.

Likewise, jurisdiction was not conferred to the AHC pursuant to subsection 2 of section 208.156. At about the same time Hospitals filed their complaints with the AHC, they sent letters to DMS demanding additional reimbursements for the period January 1, 1990, through June 30, 1995, based on the ***Great Plains*** decision. It appears that Hospitals filed their complaints with the AHC within 30 days of DMS's decisions denying their demands for additional reimbursement as required by section 208.156.8.[5] The AHC, however, found that Hos-

[5]Section 208.156.8 provides, in pertinent part:

> Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his petition for review with the administrative hearing commission.

§ 208.156.8.

pitals' demands were not timely filed under the DMS regulations and that Hospitals did not have a legal right to demand additional payments outside the normal rate-setting period. Thirteen CSR 70-3.100 establishes the general rules for submission or resubmission of claims and adjustments of claims to Missouri Medicaid. **13 CSR 70-3.100 (1998)**. It provides specific time periods for the filing by participating providers of original claims and adjustments to paid claims requesting Medicaid reimbursements. ***Id***. The time limit for filing an adjustment is provided in 13 CSR 70.3-100(6). Subsection six provides, "Adjustments to a paid claim must be filed within eighteen (18) months from the date of payment." **13 CSR 70-3.100(6)**. In this appeal, Hospitals do not contest the AHC ruling that their claims for additional reimbursements were untimely under 13 CSR 70-3.100(6). The issue is, therefore, abandoned. ***Kabir v. Missouri Dep't of Soc. Servs.*, 845 S.W.2d 102, 102-103 (Mo. App. W.D. 1993)**. The AHC did not obtain jurisdiction in this case based on section 208.156.2.

Although Hospitals were foreclosed from bringing this case on jurisdictional grounds, Hospitals had a prior mechanism to assert their claims. In section 208.156.4, the General Assembly provides a procedure to contest a rule or regulation as enacted to determine its legal validity. Had Hospitals brought complaints challenging the validity of the psychiatric cap regulation during the time when the regulation was in effect, as did the hospitals in ***Great Plains*** and the two companion cases, the AHC would have had jurisdiction over the complaints pursuant to section 208.156.4. § **208.156.4; *Great Plains*, 930 S.W.2d at 438**. Additionally, the General Assembly provides a remedy under section 208.156.2 for providers whose timely claims to

DMS are denied. Had Hospitals timely submitted their claims for adjustments under the regulations and then filed their complaints with the AHC within 30 days of DMS's denial of those claims, the AHC would have had jurisdiction in the case. §§ **208.156.2 and 208.156.8**; ***Livingston Manor*, 809 S.W.2d at 157.** To hold otherwise would allow providers to demand additional reimbursements from the State indefinitely for prior rate periods after regulations have been modified or withdrawn or payments have been made. Such a policy would confound the budgetary process of state government. Additionally, allowing providers to file claims indefinitely and to effectively force DMS to issue a new decision denying the claims, which would provide the basis for a new appeal period under section 208.156.2, would have the affect of negating the 30-day requirement of section 208.156.8.

The AHC abused its discretion in finding that it had subject matter jurisdiction in this case. The judgment of qòe circuit court reversing the decision of the AHC is affirmed.

Robert G. Ulrich, J.

All concur.

APPENDIX B

BEFORE THE ADMINISTRATIVE
HEARING COMMISSION
STATE OF MISSOURI

No. 96-002218 SP

NME HOSPITALS, INC., d/b/a
LUTHERAN MEDICAL CENTER,
Petitioner,

vs.

DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,
Respondent.

MEMORANDUM AND ORDER

On October 29, 1996, NME Hospitals, Inc., d/b/a Lutheran Medical Services (NME) filed a complaint alleging that it is entitled to additional Medicaid payments from the Department of Social Services, Division of Medical Services (Department) under section 208.156.4. On December 12, 1996, NME filed a first amended complaint alleging that it is entitled to additional payments under 208.156.2, .4, and .8. On April 9, 1997, NME filed a motion for summary determination. On June 23, 1997, the Department filed a response, and its own motion for summary determination.

After completion of the briefing, this Commission convened a hearing for oral argument on the motions on January 7, 1998. Richard D. Watters, with Lashly & Baer, represented NME. Paul G. Taylor, with Myers,

Taylor & Whitworth, represented amici Missouri Healthcare System, L.P., and Columbia Independence Regional Hospital. Terry C. Allen, with Allen & Holden Law Offices, L.L.C., represented amici Baptist Medical Center, Menorah Medical Center, Park Lane Medical Center, Trinity Lutheran Hospital, and Truman Medical Center. Kathleen Knepper represented the Department. The matter became ready for our decision on January 28, 1998, the date the transcript was filed.

We may decide this case without a hearing if either party shows undisputed facts that the other party does not dispute and that entitle that party to a favorable decision. Section 536.073.3, RSMo Supp. 1997.[1] ***ITT Commercial Fin. Corp. v. Mid-Am. Marine Supply Corp.***, 854 S.W.2d 371, 380-82 (Mo. banc 1993).

Consolidation

By order dated July 18, 1997, we consolidated this case with the following for the purposes of resolving similar legal issues: St. Louis University, d/b/a St. Louis University Hospital Medical Center (No. 96-002272 SP); Deaconess Health Services Corp., d/b/a Deaconess Hospital (No. 96-002315 SP); St. Luke's Northland Hospital Corp. (No. 96-002374 SP); St. John's Regional Health Center (No. 96-002444 SP); Psychiatric Healthcare Corp. of Missouri, d/b/a Lakeland Regional Hospital (No. 96-002663 SP); Southeast Missouri Hospital Assoc., d/b/a Southeast Missouri Hospital (No. 97-000109 SP); BHCA of Kansas City, Inc. d/b/a ValueMark Behavioral Healthcare of Kansas City, d/b/a North Hills Hospital (No. 97-000165 SP); St. John's Regional Medical Center

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[1]All statutory references, unless otherwise noted, are to the 1994 Revised Statutes of Missouri.

(No. 97-000257 SP); Deaconess Medical Center-West Campus (No. 97-000279 SP); and Lucy Lee Hospital (No. 97-000696 SP).[2] These cases are also being decided this day.

Findings of Fact

1. NME is, and was at all relevant times, a licensed hospital and authorized Medicaid provider.

2. Between January 1, 1990 and June 30, 1995 (the period), the Department reimbursed NME pursuant to a blended per diem reimbursement rate[3] calculated pursuant to the Hospital Reimbursement Plan except for psychiatric services. Psychiatric services cost less to provide than other hospital services.

3. The blended rate reimbursed providers at the same rate regardless of the type of care provided. It divided the total allowable Medicaid inpatient costs by its total Medicaid inpatient days. For example, if the average cost per day of caring for an ICU patient was $600, the average cost per day of caring for an obstetrics unit patient was $400 and the average cost per day for caring for a psychiatric unit patient was $200 per day, the state would average these numbers to determine the per diem rate of $400.[4]

4. During the period, the Department placed a "psych cap" on reimbursement of the per diem rate of inpatient psychiatric services pursuant to its Regulation 13 CSR 70-15.010(15). Thus, a provider would be paid for the

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[2]Other cases listed in that order have been dismissed.

[3]All rates are per patient day.

[4]This example assumes that there are exactly the same number of days in each unit.

covered psychiatric services at the lower of its blended rate or at the psych-capped rate. The Department continued to include the lower-cost psychiatric services costs in the blended rate, thus keeping the blended rate lower. In the above example, the provider would be paid $200 per day per the psych cap. However, the Department still used the lower cost figure in computing the average; so the provider would only be paid $400 per day for the $600 ICU patient.

5. Regulation 13 CSR 70-15.010(15) was declared invalid and void by the Circuit Court of Cole County, and by the Western District Court of Appeals in ***Missouri Dep't. of Soc. Servs. v. Great Plains Hosp., Inc.***, 930 S.W.2d 429 (Mo.. App., W.D. 1996) (***Great Plains***).[5] The Western District Court of Appeals ordered the Department to reimburse Great Plains Hospital for the difference between what it had received for inpatient psychiatric services under the psych cap per diem rate and what it would have received without the cap. Great Plains Hospital was reimbursed for this amount beginning with the adoption date of the regulation - January 1, 1990.

6. NME sent a "demand letter" to the Department on October 29, 1996, notifying the Department that it was seeking additional payment for inpatient psychiatric services during the period. The Department responded to the letter on November 27, 1996, denying further reimbursement.

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[5]The court also made this determination in companion cases ***Missouri Dep't of Soc. Servs. v. Alexian Brothers of St. Louis, Inc.***, 930 S.W.2d 439 (Mo. App., W.D. 1996) and ***Missouri Dep't of Soc. Servs. v. Trinity Lutheran Hosp.***, 930 S.W.2d 426 (Mo. App., W.D. 1996).

7. NME seeks $12,481,137 in additional payments from the Department. This is the amount that NME would have received under the blended rate had the Department not imposed the psych cap.[6]

Conclusions of Law

I. Procedural Issues

A. Objection to Affidavit

At the hearing, the Department made a motion to supplement the record to file the same documentary factual information for the other providers as was filed for NME. NME did not object to the filing of similar records. On January 22, 1998, the Department filed records including an affidavit of Jack Dothage. On January 28, 1998, NME filed a motion to strike the affidavit because it exceeds the information originally filed in that it includes claims that are unrelated to Medicaid and beyond the scope of the complaint. On January 30, 1998, the Department and all consolidated parties entered into a joint stipulation, and NME withdrew the motion to strike.

B. Objection to Affirmative Defenses

NME argues that the Department is precluded from arguing statutes of limitation afforded by sections 33.120[7] and 516.120 as affirmative defenses because such defenses were not pleaded in its answer. Our Regulation 1 CSR 15-6.380(2)(C)

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[6]The Department has accepted NME's calculation of the reimbursement shortfall due to imposition of the psych cap.

[7]The relevant portion of the statute is virtually unchanged in the 1997 Supplement.

provides that the answer shall "[a]ssert as a defense any specific failure of the complaint to comply with 1 CSR 15-6.350 or waive that defense by not asserting it[.]"

That regulation relates to failure of the complaint. The statute of limitation defense is not a defense related to that regulation. The Department has asked for leave to amend its answer to include the affirmative defenses, and we grant such leave.

II. Jurisdiction

NME claims that we have jurisdiction to hear its petition under sections 621.055 and 208.156.2, .4, and .8.

A. Aggrieved by Regulation

The Department argues that we lack jurisdiction to hear NME's petition under section 208.156.4 because the regulation in question was declared void in ***Great Plains*** and was withdrawn before NME filed its complaint. NME argues that it was aggrieved while the rule was in effect and is still aggrieved because it has not been paid. Thus, we have jurisdiction under section 208.156.4, which provides:

> 4. Any person authorized under section 208.153 to provide [Medicaid] services . . . who **is aggrieved by any . . . regulation promulgated by the department of social services** or any division therein shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

(emphasis added), and section 621.055, which provides:

> Any person authorized under section 208.153, RSMo, to provide [Medicaid] services . . . may seek review by the administrative hearing commission of any of the actions of the department of social services specified in subsection 2, 3, or 4 or section 208.156, RSMo. The review may be instituted by the filing of a petition with the administrative hearing commission.

NME asserts that it is not seeking a retroactive rate increase, but is claiming that it is aggrieved by a regulation. We agree with NME. The regulation may not exist anymore, but NME still has a claim that it is aggrieved due to the enforcement of the regulation for many years. The Department withheld money from NME based on an invalid regulation. This is money that NME at least has the right to argue was wrongfully denied.

We conclude that we have jurisdiction to hear NME's complaint under sections 621.055 and 208.156.4. NME has the burden of proving that it is entitled to additional reimbursement. Section 621.055.1.

B. Appealing a Denied Claim

NME also argues that we have jurisdiction to hear its complaint because it is appealing a final decision from the Department. Section 208.156 provides:

> 2. Any person authorized under section 208.153 to provide services for which benefit payments

> are authorized under section 208.152 whose claim for reimbursement for such services is denied or is not acted upon with reasonable promptness shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.
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> 8. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his petition for review with the administrative hearing commission . . .

NME contends that the demand letter to the Department, mailed on October 29, 1996, constitutes a claim for reimbursement that was denied by the Department. The Department argues that a provider does not have a right to demand additional payments outside of the normal rate-setting period,[8] and the denial of such a demand does not trigger a new 30-day period within which the provider may appeal an old rate. We agree with the Department. If the Department could be forced to issue a new decision -- and provide the basis for a new appeal period -- at the provider's whim, it would render the 30-day provision meaningless.

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[8]The Department cites its Regulation 13 CSR 70-3.100(6), which gives the provider 18 months from the Department's payment to seek adjustment of the claim.

See ***BHCA of Kansas City, Inc. v. Department of Soc. Servs.***, No. 96-000020 SP (Admin. Hearing Comm'n Nov. 3, 1997).

We find that we do not have jurisdiction to hear NME's petition under section 208.156.2 and .8.

III NME Not Party to Great Plains Case

The Department argues that NME is not entitled to relief *per se* as a result of the ***Great Plains*** decision because NME was not a party to the previous cases and because the cases were not filed as a class action suit. This is true; the prior decision only binds the parties. However, nothing prohibits NME from bringing its own action to determine whether it is entitled to the same or similar relief. We find that NME is not automatically entitled to the relief granted in ***Great Plains*** as a result of that decision, but that NME is not foreclosed from filing a complaint to determine whether it is entitled to relief under the same or similar legal theory.

IV Sovereign Immunity Waiver

The Department argues that NME's claims are barred by sovereign immunity that the State has not waived. Waivers of sovereign immunity must by strictly construed. ***Community Fed. Sav. & Loan Ass'n v. Director of Revenue***, 752 S.W.2d794, 796 (Mo. banc 1988). In this case, sovereign immunity has been expressly waived by statute. Section 208.156.2, .3 and .4 authorizes a hearing before this Commission if a provider has been denied reimbursement or participation in a program or is aggrieved by a rule or regulation. Section 621.055 authorizes us to order monetary relief, with interest, for any amount we find has been wrongfully denied or withheld.

In many cases before us, we have determined that the rate paid to a particular provider was legally insufficient and have ordered the Department to pay more money. This is what the statutes authorize us to do; the statutory remedy offered to the providers would be meaningless if the Department could raise the sovereign immunity defense to avoid every payment for reimbursement of money wrongfully withheld.

V. Section 33.120

Claims Barred Unless Presented Within Two Years

The Department argues that NME's claim is barred by the two-year statute of limitations found in section 33.120, which states:

> Persons having claims against the state shall exhibit the same, with the evidence in support thereof, to the commissioner of administration, for his approval, within two years after such claims accrue, and not thereafter.

However, as NME points out, the Commissioner of Administration has no control over Medicaid payments, other than to approve the total amount of all claims. Control over Medicaid cases is vested exclusively in the Department. The Medicaid money is held separate from the Commissioner of Administration's fund of public money. Section 208.170.2. Section 208.170.8 provides:

> The Title XIX fund shall consist of moneys appropriated by the state and such money as may be received from the federal government or other sources for the payment of medical assistance rendered to eligible recipients pursuant to the Title XIX state plan, and all checks payable on behalf of

> recipients shall be drawn on and paid from this fund.

The statutes have set forth a method for appealing Medicaid payments that the provider believes have been wrongfully withheld. Nowhere in the statutory scheme is it deemed necessary to apply to or exhibit the claim to the Commissioner of Administration. We find that the two-year statute of limitation under section 33.120 does not bar any portion of NME's claim.

VI. Chapter 516

The Department argues that NME's claim is barred by the five-year statute of limitation found in section 516.120. NME argues that this statute of limitations does not apply because Chapter 208 sets forth the complete and exclusive procedure for Medicaid and that any limitation period, such as the 30-day statute of limitation to file an appeal from the Department's decisions, must be established within that chapter. NME states that if any statute of limitation in Chapter 516 applies, it would be the ten-year statute of limitation found in section 516.110.

Section 516.100 describes the actions subject to the differing statutes of limitation:

> **Civil actions, other than those for the recovery of real property, can only be commenced within the periods prescribed in the following sections**, after the causes of action shall have accrued; provided, that for the purposes of sections 516.100 to 516.370, the cause of action shall not be deemed to accrue when the wrong is done or the technical breach of contract or duty occurs, but when the damage resulting therefrom is sustained

and is capable of ascertainment, and, if more than one item of damage, then the last item, so that all resulting damage may be recovered, and full and complete relief obtained.

(Emphasis added.)

Section 516.110 sets forth a ten-year statute of limitation as follows:

Within ten years:

(1) An action upon any writing, whether sealed or unsealed for the payment of money or property;

(2) Actions brought on any covenant or warranty contained in any deed of conveyance of land shall be brought within ten years next after there shall have been a final decision against the title of the covenantor in such deed, and actions on any covenant of seizin contained in any such deed shall be brought within ten years after the cause of such action shall accrue;

(3) Actions for relief, not herein otherwise provided for.

Section 516.120 sets forth a five-year statute of limitation as follows:

Within five years:

(1) All actions upon contracts, obligations or liabilities, express or implied, except those mentioned in section 516.110, and except upon judgments or decrees of a court of record, and except where a different time is herein limited;

(2) An action upon a liability created by a statute other than a penalty or forfeiture;

(3) An action for trespass on real estate;

(4) An action for taking, detaining or injuring any goods or chattels, including actions for the recovery of specific personal property, or for any other injury to the person or rights of another, not arising on contract and not herein otherwise enumerated;

(5) An action for relief on the grounds of fraud, the cause of action in such case to be deemed not to have accrued until the discovery by the aggrieved party, at any time within ten years, of the facts constituting the fraud.

While NME and the Department argue whether the action should be considered an action upon a contract under section 516.120 (1) or an action upon any writing under section 516.110, this Commission believes that the logical placement for an action to recover money owed under Medicaid statutes would be section 516.120(2)-"[a]n action upon a liability created by a statute other than a penalty or forfeiture[.]"

However, because of the language in section 516.100, we find that neither 516.110 nor 516.120 applies in this case. Section 516.100 states that the limitation on filing suit will apply to "civil actions." While this could be read broadly to mean any action that is not criminal, the number of times that the legislature and the courts distinguish between civil actions and administrative agency proceedings convince us that the two have separate meanings.

This Commission is an agency as defined by section 536.010(1). We hear contested cases, "proceeding[s] before an agency in which legal rights, duties or privileges of specific parties are required by law to be determined after hearing[.]" Section 536.010(2). Chapter 536, not the Missouri Rules of Civil Procedure, sets forth our procedures. The statute authorizing the granting of attorney fees makes the distinction between agency proceedings and civil actions:

> A party who prevails in an **agency proceeding or civil action** arising therefrom, brought by or against the state, shall be awarded those reasonable fees and expenses incurred by that party in the **civil action or agency proceeding**, unless the court or agency finds that the position of the state was substantially justified or that special circumstances make an award unjust.

Section 536.087.1 (emphasis added). *See also* ***State ex rel. Div. of Transp. v. Sure-Way Transp., Inc.***, 948 S.W.2d 651, 655-57 (Mo. App., W.D. 1997) (which found that the **civil** penalty **action** arises from the **agency proceeding**).

The court in ***Davis v. Board of Educ. of City of St. Louis***, 1998 WL 36927 (Mo. App., E.D. Feb. 3, 1998) (transfer denied Apr. 22, 1998), stated that administrative actions have characteristics that separate them from both criminal and civil actions. The court stated that the administrative action does not result in possible imprisonment like a criminal action. However, the administrative action is also different from the civil action in that it can be penal in nature, prosecuted for the benefit of the public rather than the individual. *Id.*

The court in ***Reed v. City of Springfield***, 841 S.W.2d 283, 285 (Mo. App., S.D. 1992) referred to a decision by the Springfield Mayor's Commission on Human Rights and Community Relations that was followed by a petition for judicial review as a civil action for the purposes of section 514.060, but did not elaborate on its reasoning.

The only case we find in which the court applied a section 516.100 statute of limitation to a case that had before been an administrative agency is ***De Paul Hosp. School of Nursing, Inc. v. Southwestern Bell Telephone Co.***, 539 S.W.2d 542,546 (Mo. App., St.L.D. 1976). This case involved an action to recover damages, with interest, for rate overcharges that had been determined at the Public Service Commission. However, in that case, the Public Service Commission only decided the rate. The damages for overcharges were awarded by a court in civil action.

We conclude that a contested case is not a civil action, and thus, the section 516.110 and 516.120 statutes of limitation do not apply to bar NME from filing its claim.

VII. Reasonableness of Total Amount Paid

The Department asks us to consider that, even with the imposition of the psych cap, the rate paid to NME was a fair and reasonable rate. The court in ***Great Plains Hosp.***, 930 S.W.2d at 438, however, declined to consider the substantive question of total reimbursement, finding that the provider was "entitled to reimbursement for their Medicaid services under a validly promulgated plan." As ***Great Plains*** suggests, if we find that NME is entitled to reimbursement, we will simply require the Department to reimburse NME

"according to its last, validly enacted payment plan." *Id.* This plan, according to the ***Great Plains*** court, used the blended rate without the psych cap.

We note that there was no record made and no evidence presented showing that NME was paid less than is reasonable and adequte to meet the costs that an efficiently and economically operated facility must incur to provide care meeting legal standards.

VIII. Substantial Hardship to the State Finances

The Department argues that it would be ridiculous and dangerous to the State's finances to have no statute of limitation that covers an attack on a regulation such as this one. The Department points out that a party could go back twenty or thirty years and attack a regulation. However, section 208.156.4 gives a party the right to attack a regulation if "aggrieved" by it, but does not include a time frame within which the party must do so. We have set forth our reasons for finding that none of the statutes argued by the parties limit NME's action. We have searched for a "default" statute of limitation that would establish a time limit for filing any type of case that does not have its own specific statute, but can find none.

We are aware of the amount of money involved in this case and other similar cases being decided today. The Department asserts that payment of these claims will constitute a substantial hardship on the State. However, we must follow the Western District Court's prior rulings. In ***Missouri Dep't of Soc. Servs. v. Trinity Lutheran Hosp.***, 930 S.W.2d 426, 429 (Mo. Ap., W.D. 1996), the court stated that this Commission is required "to take judicial notice that the psychiatric cap [has]

been declared invalid . . .and to decide the case before it accordingly." We do not believe that we have the authority to act as the court did in ***Jones v. State Highway Comm'n***, 557 S.W.2d 225 (Mo. banc 1977), when it set forth conditions and limits on recovery under which it was abrogating sovereign immunity "in order that an orderly transition be made, that adequate financial planning take place, that governmental units have time to adjust their practices and that the legislature be afforded an opportunity to consider the subject in general." *Id.* at 231.

Summary

This Commission therefore concludes that the State waived sovereign immunity by authorizing this Commission to determine Medicaid rates, and that no statute of limitation applies to limit recovery. Because the psych cap was declared invalid in ***Great Plains***, and because ***Trinity Lutheran*** affirms our responsibility to apply this legal conclusion in other cases, we find that NME is entitled to reimbursement of the $12,481,137 that the Department withheld due to imposition of the invalid psych cap.

SO ORDERED on May 12, 1998.

/s/ Willard C. Reine
WILLARD C. REINE
Commissioner

APPENDIX C

IN THE CIRCUIT COURT OF COLE COUNTY
STATE OF MISSOURI

MISSOURI DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF MEDICAL SERVICES,
Plaintiff,

vs.

NME HOSPITAL, INC.
d/b/a LUTHERAN MEDICAL CENTER, et.al.,
Respondent.

Case No. CV198-783CC
Consolidated with:
CV198-784CC
CV198-785CC
CV198-786CC
CV198-787CC
CV198-788CC
CV198-789CC
CV198-790CC
CV198-791CC
CV198-792CC
CV198-793CC
CV 198-1299CC
CV198-1481CC

JUDGMENT AND ORDER

This case is brought before this Court for consideration of the Petitions for Judicial Review which were filed by the Department of Social Services, Division of Medical Services under 536.140 RSMo. in thirteen (13)

cases that have now been consolidated in case number CV198-783CC. The hospitals that are the Respondents herein filed complaints at the Administrative Hearing Commission on or after October 29, 1996, citing the decision in *Mo. Dept. of Social Services vs. Great Plains Hospital, Inc.*, 930 SW.2d 429 (Mo. App. W.D. 1996).[1] In that case, the Court of Appeals affirmed the decision of the Circuit Court of Cole County issued by amended order on September 7, 1995, finding a regulation of the Department which placed an upper limit or "cap" on the Medicaid rate for inpatient psychiatric services void and invalid from the date of its adoption on January 1, 1990.

The hospitals filed Motions for Summary Determination at the Administrative Hearing Commission in which they argued that they were entitled to additional payment from the State as a consequence of the decision in the *Great Plains* case. The agency filed a response to the hospitals' Motion for Summary Determination, which also served as the Department's Cross Motion for Summary Determination.

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[1]In addition to NME Hospital, Inc. d/b/a Lutheran Medical Center, the hospitals that are consolidated as Respondents in this case are: St. Louis University, d/b/a St. Louis University Medical Center; Deaconess Health Services Corp., d/b/a Deaconess Hospital; St. Luke's Northland Hospital Corp.; St. John's Regional Health Center; Psychiatric Healthcare Corp. of Missouri, d/b/a Lakeland Regional Hospital; Southeast Missouri Hospital Assoc., d/b/a Southeast Missouri Hospital; BCHA of Kansas City, Inc., d/b/a ValueMark Behavioral Healthcare of Kansas City, d/b/a North Hills Hospital; St. John's Regional Medical Center; Deaconess Medical Center-West Campus; Lucy Lee Hospital Truman Medical Center, Inc., d/b/a Truman Medical Center-East; and Missouri Healthcare System, LP.

The Department contended that the Administrative Hearing Commission lacked subject matter jurisdiction to hear the hospitals' Complaints. The Department also argued that the claims of the hospitals are barred by sovereign immunity and by certain statutes of limitations.

The Administrative Hearing Commission found on behalf of the hospitals that jurisdiction was conferred on the basis of 208.156.4 RSMo and that the statutory scheme set forth in section 208 functions as a complete waiver of the state's immunity. The Administrative Hearing Commission found as well that no statute of limitations applies to limit the period within which these providers could receive retroactive payments from the State. In so deciding, the Administrative Hearing Commission denied the Department's Cross Motion for Summary Determination.

The Department filed Petitions for Judicial Review in each case. On motion of the Department and without objection from the hospitals, the cases were consolidated.

The three attorneys representing the Respondents were afforded an opportunity to respond to the Department's Opening Brief and to participate in oral argument on December 22, 1998. The matters before the Court are matters of law and the Court considers these matters anew. *Dixon vs. Holden*, 923 S.W.2d 370 (Mo. App. W.D. 1996), *Thomas vs. Mo. Dept. of Social Services*, 805 S.W.2d 286 (Mo App. 1991). I reverse.

The Court finds that the Administrative Hearing Commission did not have jurisdiction to consider these cases. The hospitals bear the burden of demonstrating that they meet the jurisdictional requirement set forth

in 208.156.4 RSMo. Under 208.156.4 RSMo, jurisdiction is conferred in circumstances in which a "person authorized...to provide services...is aggrieved by any rule or regulation promulgated by the department of social services...(emphasis added)" Jurisdiction is not herein conferred under 208.156.4 RSMo because the regulation in question was not in effect at the time the complaints of the hospitals were filed. The regulation had been found void and invalid from the date of its adoption by Order of this Court issued on September 7, 1995, which order was affirmed on June 21, 1995 in *Mo. Dept. of Social Services vs. Great Plains Hospital, Inc.* 930 S.W.2d 429 (Mo. App. W.D. 1996). The Missouri Supreme Court on October 22, 1996 declined to review the case. In confirmatory action, the rule was formally withdrawn by the agency by emergency rulemaking, effective on October 1, 1996. As such, the rule was not in effect when the complaints were filed.

Under these circumstances, the Court finds that the Respondents were not aggrieved by the application of a rule of the Department at the time they sought to invoke the jurisdiction of the AHC. The Court finds that the intent of 208.156.4 RSMo. is to enable Medicaid providers to seek review of the construction and application of existing rules and not to enable providers to seek additional payments from the State for prior rate periods when a rule that is no longer valid had been applied. The Administrative Hearing Commission's construction of 208.156.4 RSMo. would have the effect of negating the other provisions of the statute, specifically including 208.156.8 RSMo.

The Court agrees with the Administrative Hearing Commission that jurisdiction was not conferred under 208.156.2 and 208.156.8 in that the hospitals did not

file their complaints within thirty days of any rate decision of the Department.

The Court notes that counsel representing many of the hospitals submitted a written document to the Court following oral argument in this case. The Court is not persuaded by the argument being raised. Counsel for the hospitals suggests that after the expiration of the emergency rulemaking by which the challenged rule was withdrawn and before the final rulemaking took effect, there was a lapse period between March 29, 1997, and April 30, 1997, when the rule was technically still "on the books." Even if this is true, no hospital could have been "aggrieved" by it because there is no allegation that the void rule was applied to the Medicaid rates of the hospitals any time after October 1, 1996.

In light of the Court's decision, it is unnecessary to reach the other issues that have been raised by the parties.

JUDGMENT AND ORDER

The decision of the Administrative Hearing Commission is reversed. The Administrative Hearing Commission lacked subject matter jurisdiction to hear the complaints of the hospitals and should have dismissed these cases. It is so ordered.

/s/ Thomas J. Brown
The Honorable Thomas J. Brown
January 8, 1999